COMMUNITY BASED RESIDENTIAL FACILITY (CBRF)
RESIDENT SATISFACTION EVALUATION

Wisconsin Administrative Code HFS 83.32(2)(c)1, requires that within 30 DAYS prior to the annual evaluation, the resident and his/her guardian or agent shall be offered the opportunity to complete a written or oral evaluation of the facility's services, including but not limited to the ability of the facility to identify and meet his/her needs and preferences for care. A facility-developed form may be used if it captures the identical information and is approved by the Department..

Facility Name

Resident's Name	Date Form Completed

1. All facilities must provide or make available to residents certain services. From the following list, please check the services you receive:

- ☐ Supervision
- ☐ Leisure time activities
- ☐ Family contacts
- ☐ Health monitoring
- ☐ Medication monitoring/supervision
- ☐ Help with personal care
- ☐ Help in communication
- ☐ Assistance in decision-making
- ☐ Information and Referral
- ☐ Activities in the community
- ☐ Transportation
- ☐ Access to medical services
- ☐ Limited nursing services
- ☐ Help with independent living skills
- ☐ Opportunity to socialize with others
- ☐ Transition services

Please list any other services you receive that are not included in the above list: _____

Are there other services or activities that you feel you need but are NOT provided or arranged by the CBRF? Please list:

2. Overall, I am satisfied with the services provided by this facility.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

3. The care I receive is the kind of care I desire.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

4. The facility meets my treatment preferences (choice of doctors, pharmacy, etc.)

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

5. The facility meets my preferences for services (I receive the services I need or want).

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

6. The facility offers a variety of activities for me to choose from.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Please list activities in which you take part and how often you participate: _____

_____

_____

_____

_____

_____

_____

6a. Please list any activities you would like to have but are not available: _____

_____

_____

_____

7. There appears to be enough staff on duty at all times to meet my needs as well as those of other residents.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

8. Staff members appear to know what their responsibilities are.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

9. I am treated respectfully at all times.

☐ Yes ☐ No ☐ Don't know

Comments: _____

_____

10. My rights have been explained to me.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

11. I feel that my rights are being protected.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

12. The food served:

...IS OF GOOD QUALITY ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...MEETS MY NUTRITIONAL NEEDS ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...IS PREPARED WELL ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...TASTES GOOD ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...IS ALWAYS ENOUGH ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...IS OF A WIDE VARIETY ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

...HOT FOODS ARE SERVED HOT AND COLD FOODS ARE SERVED COLD ☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

13. My room is comfortable and meets my needs.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

14. The furnishings in my room are kept in good repair.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

15. My room, as well as the rest of the facility, is kept neat and clean.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

16. I feel safe and comfortable here.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

17. People respect my privacy.

☐ Yes ☐ Somewhat ☐ No ☐ Don't Know

Comments: _____

_____

18. The facility manages my personal funds.

☐ Yes ☐ No ☐ Don't Know

If you answered "YES," do you have concerns about how the facility is handling your funds? _____

_____

_____

19. The facility gives me **WRITTEN** notices of any changes in fees or services at least 30 days before the change happens.

☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

20. Do you control and take your own medications?

☐ Yes ☐ No ☐ Don't Know

IF YOU ANSWERED "NO," have either you or your doctor signed a paper allowing the facility to control your medications and give them to you?

☐ Yes ☐ No ☐ Don't Know

Comments: _____

_____

21. If the facility assists me with my medications, I receive them:

...ON TIME
☐ Yes ☐ No ☐ Don't Know ☐ Not Applicable

Comments: _____

_____

...IN AN ACCEPTABLE MANNER
☐ Yes ☐ No ☐ Don't Know ☐ Not Applicable

Comments: _____

_____

...AS PRESCRIBED BY MY DOCTOR
☐ Yes ☐ No ☐ Don't Know ☐ Not Applicable

Comments: _____

_____

22. Any other comments regarding this facility you would like to make? (Attach extra pages if needed.)

_____

_____

_____

_____

SIGNATURE - Resident	Date Signed

OTHER PERSONS ASSISTING RESIDENT IN COMPLETING THIS EVALUATION

SIGNATURE – Guardian / Representative	Date Signed
SIGNATURE - CBRF Staff	Date Signed